Anthem
[BlueCross BlueShield]

Dental Certificate of Coverage

Anthem Dental Family [Enhanced]

Notice to Buyer: This certificate provides dental benefits only.

Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans of Maine, Inc.
Independent licensee of the Blue Cross and Blue Shield Association.
ANTHEM is a registered trademark of Anthem Insurance Companies, Inc.
The Blue Cross and Blue Shield names and symbols
are registered marks of the Blue Cross and Blue Shield Association.

DENTAL CERTIFICATE OF COVERAGE

Welcome to Anthem Blue Cross and Blue Shield (“Anthem”)! This Dental Certificate of Coverage (hereinafter "*certificate*") has been prepared by Anthem to help explain your dental care benefits. Please refer to this *certificate* whenever you require *dental services*. It describes how to access dental care, what *dental services* are covered by us, and what portion of the dental care costs you will be required to pay.

The coverage described in this *certificate* is subject in every respect to the provisions of the *group dental contract* issued to your *group*. The *group dental contract* and this *certificate* and any amendments or riders attached to the same, shall constitute the *group dental contract* under which *covered services* are provided by us.

This *certificate* should be read in its entirety. Since many of the provisions of this *certificate* are interrelated, you should read the entire *certificate* to get a full understanding of your coverage.

Many words used in the *certificate* have special meanings. These words appear in italics and are defined for you. Refer to these definitions in the Definitions section for the best understanding of what is being stated. The *certificate* also contains exclusions.

This *certificate* supersedes and replaces any *certificate* previously issued to you under the provisions of the *group dental contract*.

Read your certificate carefully. The *certificate* sets forth many of the rights and obligations between you and the *plan*. Payment of benefits is subject to the provisions, limitations and exclusions of your *certificate*. It is therefore important that you read your *certificate*.

TABLE OF CONTENTS

DEFINITIONS

This section defines terms which have special meanings. If a word or phrase has a special meaning or is a title, it will be italicized. The word or phrase is defined in this section or at the place in the text where it is used.

Appeal - A formal request by you or your representative for reconsideration of an adverse decision on a grievance or claim.

Benefit waiting period - The period of continuous coverage under this certificate that a covered person must complete following his or her effective date before dental benefits are payable for covered services. No payment will be made for expenses incurred during the benefit waiting period indicated in the Summary of Benefits.

Certificate - This summary of the terms of your benefits. It is attached to and is a part of the group dental contract and it is subject to the terms of the group dental contract.

Coinsurance - A percentage of the maximum allowed amount for which you are responsible to pay. Your coinsurance will not be reduced by refunds, rebates, or any other form of negotiated post-payment adjustments.

Coverage year - The period of time that we pay benefits for covered services. The coverage year is listed in the Summary of Benefits. If your coverage ends earlier, the coverage year ends at the same time.

Coverage year maximum - The maximum dollar amount payable for covered services for each covered person during each coverage year. If your benefit plan covers orthodontics, benefits for orthodontic services are not included in the coverage year maximum, but are subject to a separate lifetime maximum. Refer to the Summary of Benefits for any coverage year maximum or lifetime maximum amounts.

Covered person - A subscriber or dependent who has satisfied the eligibility conditions, applied for coverage, been approved by the plan and for whom premium payment has been made. Covered persons are sometimes called “you” and “your”.

Covered services - Services or treatment as described in the certificate which are performed, prescribed, directed or authorized by a dentist. To be considered covered services, services must be:

- Within the scope of the license of the provider performing the service;
- Rendered while coverage under this certificate is in force;
- Not specifically excluded or limited by the certificate; and
- Specifically included as a benefit within the certificate.

Deductible - The dollar amount of covered services listed in the Summary of Benefits for which you are responsible before we start to pay for covered services [each coverage year][during the lifetime of the covered person].

Dental service, **dental services**, **dental procedure** and **dental procedures** - The providing of dental care or treatment by a dentist to a covered person under this certificate, provided that such care or treatment is recognized by Anthem as a generally accepted form of care or treatment according to prevailing standards of dental practice.

Dentally necessary orthodontic care – A dental service where at least one of the following criteria are present: (A) There is spacing between adjacent teeth which interferes with the biting function; or (B) There is an overbite to the extent that the lower anterior teeth impinge on the roof of the mouth when the covered person bites; or (C) Positioning of the jaws or teeth impair chewing or biting function; or (D) On an objective professionally recognized dental orthodontic severity index the condition scores at a level consistent with the need for orthodontic care; or (E) Based on a comparable assessment of items (A) through (D), there is an overall orthodontic problem that interferes with the biting function.

Dentist - A person who is licensed to practice dentistry by the governmental authority having jurisdiction over the licensing and practice of dentistry. In addition, the term dentist shall include denturists acting within the scope of their license and dental hygienists who are independently licensed and are practicing within the scope of such license.

Dependent - A person of the subscriber's family who is eligible for coverage under the certificate as described in the Eligibility and Enrollment section.

Effective date - The date that a subscriber's coverage begins under this certificate. A dependent's coverage also begins on the subscriber's effective date.

Eligible person - A person who meets the group's requirements and is entitled to apply to be a subscriber.

Essential Health Benefits (EHB) – For the purposes of this coverage, Essential Health Benefits are those pediatric oral services that we are required to cover under the Affordable Patient Care Act and any other application regulations. EHB and its provisions apply to covered persons until the end of the month in which they turn 19.

Group dental contract (or contract) - The contract between the plan and the group. It includes this certificate, your application, any supplemental application or change form, and any additional legal terms added by us to the original contract. The final interpretation of any specific provision contained in this certificate is governed by the group dental contract.

Group or **group subscriber** - The employer, or other organization, that has entered into a group dental contract with the plan.

Identification Card / ID card - A card issued by the plan, showing the covered person's name, membership number, and occasionally coverage information.

Maximum allowed amount - The maximum amount of reimbursement Anthem will pay for services provided by a provider to a covered person. You will be required to pay a portion of the maximum allowed amount to the extent you have not met your deductible or have a coinsurance. There may be different levels of reimbursement for the maximum allowed amount depending upon whether you elect to receive services from a participating dentist or a non-participating dentist. The maximum allowed amount will always be the lesser of the maximum amount of reimbursement established by Anthem or the provider's billed charges.

Non-participating dentist - A dentist who has NOT signed a written provider service agreement agreeing to service the program identified in this certificate. Anthem will reimburse non-participating dentists according to the maximum allowed amount for non-participating dentists, also referred to in this certificate as the Table of Allowances. The Table of Allowances may be different from the maximum allowed amount reimbursed to participating dentists.

Open enrollment - An enrollment period when any eligible subscriber or dependent of the group may apply for this coverage.

Participating dentist - A dentist who has signed a written provider service agreement agreeing to service the program identified in this certificate. The dentist has agreed to accept Anthem's Schedule of Maximum Allowable Charges as payment in full for dental care covered under this certificate.

Plan (or we, us, our) - Anthem Blue Cross and Blue Shield. Also referred to as Anthem.

Premium - The periodic charges due which the covered person or the group must pay the plan to maintain coverage.

Pretreatment estimate - A request by a covered person or dentist to Anthem in advance of a dental service being provided to determine the covered person's benefits, estimate the maximum allowed amount, and estimate the amount of the covered person's financial liability. A pretreatment estimate is not a guaranty of benefits or a guaranty of payment of benefits.

Prior plan - The plan sponsored by the group which was replaced by the benefits under this certificate within 60 days. You are considered covered under the prior plan if you: (1) were covered under the prior plan on the date that plan terminated; (2) properly enrolled for coverage within 31 days of this certificate's effective date; and (3) had coverage terminate solely due to the prior plan's termination.

Provider - A duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that the plan approves. This includes any provider rendering services that are required by applicable state law to be covered when rendered by such provider.

Schedule of Maximum Allowable Charges - A schedule of maximum allowed amounts established by Anthem for services rendered by participating dentists servicing this program.

Subscriber - An employee or member of the group who is eligible to receive benefits under the group dental contract.

Table of Allowances - A schedule of fixed dollar maximum allowed amounts established by Anthem for services rendered by non-participating dentists.

SUMMARY OF BENEFITS

The Summary of Benefits is a summary of the *deductibles*, *coinsurance* and other limits when you receive *covered services* from a *provider*. Please refer to the Covered Services section of your *certificate* for a more complete explanation of the specific services covered by the *plan*. All *covered services* are subject to the conditions, exclusions, limitations, terms and provisions of this *certificate* including any attachments or riders.

Coverage Year
A *coverage year* is a 12-month period in which *deductibles* and benefit maximums apply. Your *coverage year* is January 1st through December 31st.

Deductible
The *deductible* is the amount you must pay before we begin to pay for *covered services*. You have to meet your *deductible* every *coverage year* before we will pay for *covered services*.

Deductible amount for members through the end of the month in which they turn 19$[25][50] per *covered person*
[*Deductible* amount for members age 19 and older.....$50 per *covered person*]

Waiting Periods
A *benefit waiting period* is the length of time you must be covered under this *policy* before we pay benefits. Certain types of services may have *benefit waiting periods* under your *policy*. You are eligible for benefits once you meet your *benefit waiting periods*.

Type of Service	**Waiting Period**
[For covered persons age 19 and older	
Basic Restorative	6 months
Endodontic Services	12 months
Periodontal Services	12 months
Oral Surgery Services	12 months
Major Restorative Services	12 months
Prosthodontic Services	12 months]
[For covered persons through the end of the month in which they turn 19	
Cosmetic Orthodontic Care	12 months]

Benefit Maximum
The following benefit maximums are the dollar amount we will pay for *covered services* for each *covered person*, subject to the *coverage percentages* identified above. If you do not reach your annual benefit maximums, unused amounts will not carry over to the next *coverage year*.

	Participating Dentist	**Non-Participating Dentist**
Annual Benefit Maximum (*for covered persons through the end of the month in which they turn 19*)	no limit	
Dentally necessary orthodontic care Lifetime Benefit Maximum	no limit	
[Cosmetic Orthodontic Care Lifetime Benefit Maximum	$1,000 *(combined for participating and non-participating dentists)]*	
Annual Benefit Maximum (*for covered persons age 19 and older*)	$[750][1,000] *(combined for participating and non-participating dentists)*	

Annual Out of Pocket Maximum
For *covered persons* through the end of the month in which they turn 19, there is an annual out of pocket maximum. This amount is the most you will pay out of pocket in a *coverage year* for *essential health benefits* before we will pay 100% of the *maximum allowed amount* for *essential health benefits*. Your *premium* amount, charges for services that are not covered, or charges for services received from a *non-participating dentist* do not apply to the out of pocket maximum.

Annual Out of Pocket Maximum for 1 child $350
Annual Out of Pocket Maximum for 2 or more children $700

Coverage Percentages
After you have met any applicable *deductibles*, we pay the following percentages of the *maximum allowed amount* for *covered services*. The *maximum allowed amount* is different for *participating and non-participating dentists*. If you see a *non-participating dentist*, you may have more out-of-pocket expenses. To learn more about how the *maximum allowed amount* is determined, see the section called Dental Providers and Claims Payments.

Essential Health Benefits
The following benefits are available to *covered persons* through the end of the month in which they turn 19 only. You have to meet your *deductible* before we will pay for *covered services*. However, the *deductible* is waived for fluoride treatments.

Type of Service	Participating Dentists	Non-Participating Dentists
Diagnostic & Preventive Services	100%	[70][80]%
Basic Restorative Services	[60][80]%	[50][60]%
Endodontic Services	[50][80]%	50%
Periodontal Services	[50][80]%	50%
Oral Surgery Services	[50][80]%	50%
Major Restorative Services	50%	50%
Prosthodontic Services	50%	50%
Dentally Necessary Orthodontic Care	50%	50%
[Cosmetic Orthodontic Care	50%	50%]

Covered persons age 8 through age 18 may be eligible for Cosmetic Orthodontic Care if the recommended treatment is not eligible for Dentally Necessary Orthodontic Care. Cosmetic Orthodontic Care is not an Essential Health Benefit.

Adult Dental Benefits
The following benefits are available to *covered persons* age 19 and older only. You have to meet your *deductible* before we will pay for *covered services*.

Type of Service	Participating Dentists	Non-Participating Dentists
Diagnostic & Preventive Services	100%	50%
Basic Restorative Services	[50][80]%	[25][40]%
Endodontic Services	[30][50]%	[15][25]%
Periodontal Services	[30][50]%	[15][25]%
Oral Surgery Services	[30][50]%	[15][25]%
Major Restorative Services	[30][50]%	[15][25]%
Prosthodontic Services	[30][50]%	[15][25]%
Orthodontic Services	Not covered	Not covered

ELIGIBILITY AND ENROLLMENT

Your Eligibility requirements are described in general terms below. For more specific eligibility information, see your Human Resources or Benefits Department.

ELIGIBILITY

Subscriber To be eligible to enroll as a *subscriber*, you must:

a) [Be an employee of the *group*;

b) Be entitled to participate in the benefit *plan* arranged by the *group*; and

c) Have satisfied any probationary or *waiting periods* established by the *group*.]

Dependents

A) Spouse, meaning:
   1. Married;
   2. Legally separated;
   3. Qualified domestic partner of an eligible employee, if all of the following criteria are met:
      a. are not related by blood closer than permitted under applicable State marriage laws;
      b. are not married and do not have any other domestic partners;
      c. are at least eighteen (18) years of age and have the capacity to enter into a contract;
      d. share a residence;

      NOTE: All references to spouse in this *certificate* include qualified domestic partners.

B) Dependent children to the age of 26 that are the *subscriber's* or the *subscriber's* spouse's, including:
   1. Natural-born and legally adopted children (including children placed with you for legal adoption). NOTE: A child's placement for adoption terminates upon the termination of the legal obligation of total or partial support.
   2. Stepchildren who reside with you.
   3. Children of the domestic partner of the employee. NOTE: Children of a domestic partner are eligible only as long as the domestic partner is covered and they must qualify as a Domestic Partner's dependent for Federal tax purposes.
   4. Grandchildren for whom you are the legal guardian.
   5. Children who are required to be covered by reason of a Qualified Medical Child Support Order. You can obtain, without charge, a copy of procedures governing Qualified Medical Child Support Orders ("QMCSOs") from the *Plan* Administrator.
   6. Unmarried children may continue coverage past the above stated age limit if they cannot work to support themselves because
      - they are primarily dependent upon you; and
      - are incapable of self-sustaining employment because of physical handicap, developmentally delayed, mental illness or mental disorders.

NOTE: If both you and your spouse are employees of the employer, you may be covered as either an employee or as a *dependent*, but not both. Your eligible dependent children may be covered under either parent's coverage, but not both.

Effective Dates of Coverage

Subscriber:

You are eligible to be covered under this *certificate* when it first became effective, [effective date] or if you are a new employee of the *group*, on the date following your company's probationary period.

Eligible Dependents:

Your eligible *dependents*, as defined, are covered under this *certificate*:

a) On the date you first become eligible for coverage, if dependent coverage is provided or elected.

b) On the date you first acquire eligible *dependents*, or add dependent coverage subject to the o*pen enrollment* requirements of the *group*, if any.

c) On the date a new *dependent* is acquired if you are already carrying dependent coverage.

LIMITATION: *Dependents* of an eligible employee who are in active military service are not eligible for coverage under the *certificate*.

Children may be added to the *contract* at the time the eligible employee originally becomes effective or may be added anytime up to 30 days following the child's 3rd birthday. If a child is born or adopted after the employee's original *effective date*, such child may be added anytime between birth (or date of adoption) and 30 days following the child's 3rd birthday. In the event that the child is not added by 30 days following their 3rd birthday, that child may be added only if there is a Family Status Change or at the next *open enrollment* period, if any.

The eligibility of all members, for the purposes of receiving benefits under the *certificate*, shall, at all times, be contingent upon the applicable monthly payment having been made for such member by the *group* on a current basis.

Open Enrollment

Contact your employer for your designated *open enrollment* period, if any.

Family Status Change

Your benefit elections are intended to remain the same for the entire *coverage year*. During the *coverage year*, you will be allowed to change your benefits only if you experience an eligible Family Status Change which includes:

- Change in legal marital status such as marriage or divorce.
- Change in number of *dependents* in the event of birth, adoption, or death.
- Change in your [parent's or legal guardian's][or your spouse's] employment - either starting or losing a job.
- Change in your [parent's or legal guardian's][or your spouse's] work schedule, such as going from full-time to part-time or part-time to full-time, or beginning or ending an unpaid leave of absence.
- Change in *dependent* status, such as if a child reaches maximum age under the *certificate*.
- Change in residence or work location so you are no longer eligible for your current health plan.
- Become eligible for Medicare, Medicaid or Children's Health Insurance Program (CHIP) coverage.
- Termination of Medicare, Medicaid or Children's Health Insurance Program (CHIP) coverage because you [or your *dependents*] are no longer eligible.
- Loss of other coverage.

Due to federal regulations, the changes you make to your benefits must be consistent with the Family Status Change event that you experience. For example, if you have gain a spouse, it is consistent to add your spouse to your current dental coverage but it is not consistent to drop your dental coverage altogether.

If you experience one of the above eligible Family Status Changes during the year, you have 31 days (except in the case of qualification for or termination of employment assistance under Medicaid/CHIP, in which case the employee has 60 days after the date of eligibility) from the event to change your elections. If you do not change your benefits within 31 days of the event, you will not be allowed to make changes until the next *open enrollment* period. You may obtain a Family Status Change Form by contacting your Employer. All changes are effective the date of the change.

The *group* reserves the right to terminate the *contract*, in whole or in part, at any time (subject to applicable collective bargaining agreements). Termination of the *contract* will result in loss of benefits for all members. If the *contract* is terminated, the rights of the members are limited to *maximum allowed amount* for *covered services* incurred before termination.

TERMINATION AND CONTINUATION

Except as otherwise provided, your coverage may terminate in the following situations. The information provided below is general and the actual *effective date* of termination may vary based on your *group's* agreement with us and your specific circumstances, such as whether the *premium* has been paid in full.

Termination of Coverage

Your coverage and that of your eligible *dependents*, if any, ceases on the earliest of the following dates:

a) The end of the month in which (1) you cease to be eligible[; (2) your *dependent* is no longer eligible as a *dependent* under the *certificate*].

b) On the date the *certificate* is terminated.

c) On the date the *group* terminates the *certificate* by failure to pay the *premiums*, except as a result of inadvertent error.

d) The date the *premium* payment was due but no payment was received, subject to the grace period.

When a Child's Coverage Ends

Covered children will receive benefits for the *essential health benefit* coverage in this policy until the end of the month in which they turn age 19. At the end of the month in which they turn 19, unless we are given notice to cancel, they will be covered under the Adult Dental Benefits in this *policy* to the end of the month in which they reach age 26, unless they are disabled. Please see the Who is Eligible section for more information.

For extended eligibility, see Continuation of Coverage.

Notification Prior to Termination

A written notification will be sent 10 days prior to the date the *plan* terminates. You have the right to designate an individual of your choice, or to change this designation, to receive this notification.
If you request a third party designation form, it will be mailed to you within 10 days of your request. In the event that your coverage under the *plan* is terminating due to non-payment of *premium* due to a cognitive impairment or functional incapacity, your coverage may be reinstated. You or a person authorized to act on your behalf, must request reinstatement within 90 days after termination. Upon reinstatement, you will have 15 days to pay any unpaid *premium* from the date of the last *premium* payment at the rate that would have been in effect had the policy not been terminated. If you do not pay the unpaid *premium* in within this time, your coverage may not be reinstated and we are not responsible for claims incurred after the initial date of cancellation.

Renewability

This plan will renew annually at the option of your group as long as premiums are paid (subject to the grace period), and the plan is not otherwise cancelled according to the Termination and Continuation section.

Continuation of Coverage (COBRA)

Dental benefits may be continued should any of the following events occur, provided that at the time of occurrence this *certificate* remains in effect and you or your spouse or your dependent child is a member under this *certificate*:

QUALIFYING EVENT	WHO MAY CONTINUE	MAXIMUM CONTINUATION PERIOD
Employment ends, retirement, leave of absence, lay-off, or employee becomes ineligible (except gross misconduct dismissal)	*Subscriber* and *dependents*	Earliest of: 1. 18 months, or 2. Enrollment in other group coverage or Medicare, or 3. Date coverage would otherwise end.
Divorce, marriage dissolution, or legal separation	Former spouse and any dependent children who lose coverage	Earliest of: 1. 36 months, or 2. Enrollment date in other group coverage or Medicare, or 3. Date coverage would otherwise end.
Death of *Subscriber*	Surviving spouse and dependent children	Earliest of: 1. 36 months, or 2. Enrollment date in other group coverage or Medicare, or 3. Date coverage would otherwise end.
Dependent child loses eligibility	Dependent child	Earliest of: 1. 36 months, or 2. Enrollment date in other group coverage or Medicare, or 3. Date coverage would otherwise end.
Dependents lose eligibility due to *Subscriber's* entitlement to Medicare	Spouse and *dependents*	Earliest of: 1. 36 months, or 2. Enrollment date in other group coverage or Medicare, or 3. Date coverage would otherwise end.
Subscriber's total disability	*Subscriber* and *dependents*	Earliest of: 1. 29 months, or 2. Date total disability ends, or 3. Enrollment date in other group coverage or Medicare.
Retirees of employer filing Chapter 11 bankruptcy (includes substantial reduction in coverage within 1 year of filing)	Retiree and *dependents*	Earliest of: 1. Enrollment date in other group coverage, or 2. Death of retiree or Dependent electing COBRA.
Surviving *dependents* of retiree on lifetime continuation due to the bankruptcy of the employer	Surviving spouse and *dependents*	Earliest of: 1. 36 months following retiree's death, or 2. Enrollment date in other group coverage.

You or your eligible *dependents* have 60 days from the date you lose coverage, due to one of the events described above, to inform the *group* that you wish to continue coverage.

1. Choosing Continuation

   If you lose coverage, your employer must notify you of the option to continue coverage within 10 days after employment ends. If coverage for your *dependent* ends because of divorce, legal separation, or any other change in dependent status, you or your covered *dependents* must notify your employer within 60 days.

   You or your covered *dependents* must choose to continue coverage by notifying the employer in writing. You or your covered *dependents* have 60 days to choose to continue, starting with the date of the notice of continuation or the date coverage ended, whichever is later. Failure to choose continuation within the required time period will make you or your covered *dependents* ineligible to choose continuation at a later date. You or your covered *dependents* have 45 days from the date of choosing continuation to pay the first continuation charges. After this initial grace period, you or your covered *dependents* must pay charges monthly in advance to the employer to maintain coverage in force.

   Charges for continuation are the group rate plus a two percent administration fee. All charges are paid directly to your employer. If you or your covered *dependents* are totally disabled, charges for continuation are the group rate plus a two percent administration fee for the first 18 months. For months 19 through 29, the employer may charge the group rate plus a 50 percent administration fee.

2. Second qualifying event

   If a second qualifying event occurs during continuation, a dependent qualified beneficiary may be entitled to election rights of their own and an extended continuation period. This rule only applies when the initial qualifying event for continuation is the employee's termination of employment, retirement, leave of absence, layoff, or reduction of hours.

   When a second qualifying event occurs such as the death of the former covered employee, the Dependent must notify the employer of the second event within 30 days after it occurs in order to continue coverage. In no event will the first and second period of continuation extend beyond the earlier of the date coverage would otherwise terminate or 36 months.

   A qualified beneficiary is any individual covered under the health *plan* the day before the qualified event as well as a child who is born or placed for adoption with the covered employee during the period of continuation coverage.

3. Terminating Continuation of Coverage - COBRA

   Continuation of Coverage - COBRA for you and your eligible *dependents*, if selected, shall terminate on the last day of the month in which any of the following events first occur:

   a) The expiration of the specified period of time for which Continuation of Coverage - COBRA can be maintained; as mandated by applicable State or Federal law;

   b) This *certificate* is terminated by the *group subscriber*;

   c) The *group subscriber's* or member's failure to make the payment for the member's continuation of coverage

   Questions regarding continuation of coverage - COBRA should be directed to your employer. Your employer will explain the regulations, qualifications and procedures required when you continue coverage.

DENTAL PROVIDERS AND CLAIMS PAYMENT

You do not have to select a particular dentist to receive dental benefits. You have the freedom to choose the dentist you want for your dental care. However, your dentist choice can make a difference in the benefits you receive and the amount you pay. You may have additional out-of-pocket costs if your dentist is a *non-participating dentist*. There may be differences in the payment amount compared with a *participating dentist* if your dentist is a *non-participating dentist*.

Please note: a dentist is a person who is licensed to practice dentistry by the governmental authority having jurisdiction over the licensing and practice of dentistry, including dental hygienists and denturists who are acting within the scope of their license.

PAYMENTS ARE MADE BY ANTHEM ONLY WHEN THE COVERED *DENTAL PROCEDURES* HAVE BEEN COMPLETED. THE *PLAN* MAY REQUIRE ADDITIONAL INFORMATION FROM YOU OR YOUR *PROVIDER* BEFORE A CLAIM CAN BE CONSIDERED COMPLETE AND READY FOR PROCESSING. IN ORDER TO PROPERLY PROCESS A CLAIM, THE *PLAN* MAY BE REQUIRED TO ADD AN ADMINISTRATIVE POLICY LINE TO THE CLAIM. DUPLICATE CLAIMS PREVIOUSLY PROCESSED WILL BE DENIED.

This section describes how we determine the amount of reimbursement for *covered services*. Reimbursement for *dental services* rendered by *participating* and *non-participating dentists* is based on the *maximum allowed amount* for the type of service performed. There may be different levels of reimbursement for the *maximum allowed amount* depending upon whether you elect to receive services from a *participating* or a *non-participating dentist*.

The *maximum allowed amount* is the maximum amount of reimbursement Anthem will pay for *dental services* provided by a dentist to a *covered person* and which meet our definition of a *covered service*. For *participating dentists*, the *maximum allowed amount* will be reimbursed according to the *Schedule of Maximum Allowable Charges*. For *non-participating dentists*, the *maximum allowed amount* will be reimbursed according to the *Table of Allowances*.

You will be required to pay a portion of the *maximum allowed amount* to the extent you have not met your *deductible* or have a *coinsurance*. In addition, when you receive *covered services* from a *non-participating dentist*, you may be responsible for paying any difference between the *maximum allowed amount* and the *dentist's* actual charges. This amount may be significant.

When you receive *covered services* from a dentist, we will apply processing rules to the claim submitted for those *covered services*. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the *dental procedure*. Applying these rules may affect our determination of the *maximum allowed amount*. For example, your dentist may have submitted the claim using several procedure codes when there is a single procedure code that includes all or a combination of the procedures that were performed. When this occurs, our payment will be based on a single *maximum allowed amount* for the single procedure code rather than a separate *maximum allowed amount* for each billed procedure amount.

Likewise, when multiple procedures are performed on the same day by the same dental *provider* or other dental *providers*, we may reduce the *maximum allowed amount* for those additional procedures, because reimbursement at 100% of the *maximum allowed amount* for those procedures would represent a duplicate payment for a *dental procedure* that may be considered incidental or inclusive.

Provider network status

The *maximum allowed amount* may vary depending upon whether the *provider* is a *participating dentist* or a *non-participating dentist*. There may be different levels of reimbursement for the *maximum allowed*

amount depending upon whether you elect to receive services from a *participating dentist* or a *non-participating dentist*.

Participating dentists

A *participating dentist* is a dentist who has signed a written provider service agreement agreeing to service the program identified in this *certificate*. For *covered services* performed by a *participating dentist*, the *maximum allowed amount* is based upon the lesser of the *dentist's* actual charges or the *Schedule of Maximum Allowable Charges*. Because *participating dentists* have agreed to accept the *maximum allowed amount* as payment in full for services, they should not send you a bill or collect for amounts above the agreed upon *maximum allowed amount*. However, you may receive a bill or be asked to pay a portion of the *maximum allowed amount* to the extent you have exhausted your coverage for the service, have not met your *deductible*, have a *coinsurance*, have received *non-covered services*, or have exceeded the dental benefit maximum as outlined in the Summary of Benefits. Please call member service at [(800) 627-0004] for help in finding a *participating dentist* or visit our website at www.anthem.com/mydentalvision. Please refer to your *ID card* for the name of the dental program that participating *providers* have agreed to service when you are choosing a participating provider.

Non-participating dentists

Dentists who have NOT signed a written provider service agreement agreeing to service the program identified in this *certificate* are considered *non-participating dentists*. For *covered services* you receive from a *non-participating dentist*, the *maximum allowed amount* will be the lesser of the *dentist's* actual charges or the amount determined by us as follows:

[[1.] An amount based on our *non-participating dentist* fee schedule, referred to as the *Table of Allowances*, which we have established in our discretion, and which we reserve the right to modify from time to time after considering one or more of the following: reimbursement amounts accepted by similar *providers* contracted with us, and other industry cost, reimbursement and utilization data. The *Table of Allowances* [is] [may be] different from the *maximum allowed amount* reimbursed to *participating dentists*;] [.] [or]

[2. An amount based on information provided by a third party vendor, which may reflect comparable *providers'* fees and costs to deliver care;] [.] [or]

[3. An amount negotiated by us or a third party vendor which has been agreed to by the *provider*.]

Unlike *participating dentists*, *non-participating dentists* may send you a bill and collect for the amount of the *dentist's* charge that exceeds our *maximum allowed amount*. You are responsible for paying the difference between the *maximum allowed amount* and the amount the *non-participating dentist* charges. This amount may be significant. Choosing a *participating dentist* will likely result in lower out of pocket costs to you. Please call member service at [(800) 627-0004] for help in finding a *participating dentist* or visit our website at www.anthem.com/mydentalvision.

Member service is also available to assist you in determining the *maximum allowed amount* for a particular service from a *non-participating dentist*. In order for us to assist you, you will need to obtain the specific procedure code(s) from your *dentist* for the services the *dentist* will render. You will also need to know the *dentist's* charges to calculate your out of pocket responsibility. Although member service can assist you with this pre-service information, the *maximum allowed amount* for your claim will be based on the actual claim submitted.

Member cost share

For certain *covered services* and depending on your dental program, you may be required to pay a part of the *maximum allowed amount* (for example, *deductible* and/or *coinsurance*). Your *deductible* and *coinsurance* cost share amount and out-of-pocket limits may vary depending on whether you received services from a *participating* or *non-participating dentist*. Specifically, you may pay higher cost sharing amounts or incur benefit limits when using *non-participating dentists*. Please see the Summary of Benefits in this *certificate* for your cost share responsibilities and limitations, or call member service to learn how this *certificate's* benefits or cost share amounts may vary by the type of *dentist* you use.

Payment of benefits

You authorize us to make payments directly to *participating dentists* for *covered services*. We also reserve the right to make payments directly to you. Payments may also be made to, and notice regarding the receipt and/or adjudication of claims, an alternate recipient, or that person's custodial parent or designated representative. Any payments made by us will discharge our obligation to pay for *covered services*.

Once a *provider* gives a *covered service*, we will not honor a request for us to withhold payment of the claims submitted.

THE *COVERED PERSON* IS RESPONSIBLE FOR ALL TREATMENT CHARGES MADE BY A *NON-PARTICIPATING DENTIST*. WHEN SERVICES ARE OBTAINED FROM A *NON-PARTICIPATING DENTIST*, ANY BENEFITS PAYABLE UNDER THE *GROUP CONTRACT* ARE PAID DIRECTLY TO THE *COVERED PERSON*, UNLESS THE *COVERED PERSON* HAS ASSIGNED THEIR BENEFIT TO THE *DENTIST* WHO PROVIDED THE SERVICE.

Notice of claim

We are not liable under the *certificate*, unless we receive written notice that *covered services* have been given to you. An expense is considered incurred on the date the service or supply was given.

The notice must be given to us within [90 days – 12 months] of receiving the *covered services*, and must have the data we need to determine benefits. Failure to give us notice within [90 days – 12 months] will not reduce any benefit if you show that the notice was given as soon as reasonably possible. No notice can be submitted later than one year after the usual [90 day – 12 month] filing period ends. If the notice submitted does not include sufficient data we need to process the claim, then the necessary data must be submitted to us within the time frames specified in this provision or no benefits will be payable except as otherwise required by law.

Any benefits due under this *certificate* shall be due once we have received proper, written proof of loss, together with such reasonably necessary additional information we may require to determine our obligation. In the event we do not pay a claim within 30 days of receipt of proof of loss, we will pay interest at the rate required by law on the benefits due under the terms of the *certificate*.

Claims should be submitted to:

Anthem Blue Cross and Blue Shield
[PO Box 9385
Minneapolis, MN 55440-9385
(800) 234-9009]

Proof of claim

Written proof of claim satisfactory to us must be submitted to us within 12 months after the date of the event for which claim is made. If proof of claim is not sent within the time required, the claim will not be reduced or denied if it was not possible to send proof within this time. However, the proof must be sent as soon as reasonably possible. In any case, the proof required must be sent to us no later than one year following the 12 month period specified, unless you were legally incapacitated.

Claim forms

Many *providers* will file a claim form for you. If the forms are not available, either send a written request for claim forms to us or contact member service and ask for claim forms to be sent to you. The form will be sent to you within 15 days. If the forms are not furnished to you within 15 days you will be deemed to have complied with the requirement to provide proof of loss under this policy.

Covered person's cooperation

Each *covered person* shall complete and submit to the *plan* such authorizations, consents, releases, assignments and other documents as may be requested by the *plan* in order to obtain or assure reimbursement under Medicare, Worker's Compensation or any other governmental program. Any *covered person* who fails to cooperate will be responsible for any charge for services.

Explanation of Benefits

After you receive dental care, you will often receive an Explanation of Benefits (EOB). The EOB is a summary of the coverage you receive. The EOB is not a bill, but a statement from us to help you understand the coverage you are receiving. The EOB shows:

- total amounts charged for services/supplies received;
- the amount of the charges satisfied by your coverage;
- the amount for which you are responsible (if any);
- general information about your *Appeals* rights and for ERISA plans, information regarding the right to bring an action after the *Appeals* process.

International Emergency Dental Program

This *policy* includes coverage for emergency dental care while traveling. Please see the Emergency Dental Care for the World Traveler flyer included with this *policy*.

COVERED SERVICES

Only services listed in this section are covered under this *plan*. All *covered services* are subject to the terms, limitations, and exclusions of your *plan*. See the Summary of Benefits for your cost share amounts, such as *deductibles* and/or any *coinsurance*.

Your dental benefits
Anthem does not determine whether the *dental services* listed in this section are medically necessary to treat your specific condition or restore your dentition. There is a preset schedule of dental care services that are covered under this *plan*. We evaluate the procedures submitted to us on your claim to determine if they are a *covered service* under this *plan*.

EXCEPTION: Claims for orthodontic care will be reviewed to determine if it was *dentally necessary orthodontic care*. See the section Orthodontic Care for more information. [If it is determined the care is not *dentally necessary orthodontic care*, it may be covered at the cosmetic orthodontic care rate. See the Summary of Benefits to determine if you have cosmetic orthodontic care coverage.]

Your *dentist* may recommend or prescribe other dental care services that are not covered, are cosmetic in nature, or exceed the benefit frequencies of this *plan*. While these services may be necessary for your dental condition, they may not be covered by us. There may be an alternative dental care service available to you that is covered under your *plan*. These alternative services are called optional treatments. If an allowance for an optional treatment is available, you may apply this allowance to the initial dental care service prescribed by your *dentist*. You are responsible for any costs that exceed the allowance, in addition to any *coinsurance* or *deductible* you may have.

The decision as to what dental care treatment is best for you is solely between you and your *dentist*.

Pretreatment estimates
A *pretreatment estimate* is a valuable tool for you and your *dentist*. It provides you and the *dentist* with an idea of what your out of pocket costs will be for the dental care treatment. This will allow the *dentist* and you to make any necessary financial arrangements before treatment begins. It is a good idea to get a *pretreatment estimate* for dental care that involves major restorative, endodontic, periodontic, oral surgery, prosthetic, or orthodontic care.

The *pretreatment estimate* is recommended, but it is not required for you to receive benefits for covered dental care services.

A *pretreatment estimate* does not authorize treatment or determine its medical necessity (except for orthodontics), and does not guarantee benefits. The estimate will be based on your current eligibility and the *plan* benefits in effect at the time the estimate is submitted to us. This is an estimate only. Our final payment will be based on the claim that is submitted at the time of the completed dental care service(s). Submission of other claims, changes in your eligibility or changes to the *plan* may affect our final payment.

You can ask your *dentist* to submit a *pretreatment estimate* for you, or you can send it to us yourself. Please include the procedure codes for the services to be performed (your *dentist* can tell you what procedures codes). *Pretreatment estimate* requests can be sent to the address on your dental *ID card*

Pediatric Dental
Essential Health Benefits

We cover the following dental care services for members up through the end of the month in which they turn 19.

Diagnostic and Preventive Services

Oral Exams. Covered 2 times per 12 months.

Radiographs (X-rays)

- Bitewings - Covered 2 sets per 12 months.
- Full Mouth (Complete Series) - Covered 1 time per 60 months.
- Panoramic – Covered 1 time per 60 months.
- Periapicals and
- Occlusal films.

Dental Cleaning (prophylaxis). Procedure to remove plaque, tartar (calculus), and stain from teeth. Covered 2 times per 12 months. Paid as child prophylaxis if the *covered person* is 13 or younger, and adult prophylaxis starting at age 14.

Fluoride Treatment (topical application or fluoride varnish). Covered 2 times per 12 months.

Sealants or Preventive Resin Restorations. Any combination of these procedures is covered 1 time per tooth every 36 months.

Space Maintainers and Recement Space Maintainers

Emergency Treatment (also called palliative treatment). Covered for the temporary relief of pain or infection.

Basic Restorative Services

Consultations. Covered when given by a *provider* other than your treating dentist.

Fillings (restorations). Fillings are covered when placed on primary or permanent teeth. There are two kind of fillings covered under this *plan*:

- Amalgam. These are silver fillings that are used to restore decayed or fractured posterior (back) teeth.
- Composite Resin. These are tooth-colored fillings that are used to restore decayed or fractured anterior (front) teeth. If you choose to have a composite resin filling placed on a back tooth, we will pay up to the *maximum allowed amount* for an amalgam filling. You will be responsible to pay for the difference, if the dentist charges more, plus any applicable *deductible* or *coinsurance*.

Periodontal Maintenance. This procedure includes periodontal evaluation, removing bacteria from the gum pocket areas, measuring the gum pocket areas, and scaling and polishing of the teeth. Any combination of this procedure and dental cleanings (see Diagnostic and Preventive Services above) is covered 4 times per 12 months.

Endodontic Therapy on Primary Teeth

- **Pulpal Therapy**
- **Therapeutic Pulpotomy**

Periodontal Scaling & Root Planing. This is a non-surgical periodontal service to treat diseases of the gums (gingival) and bone that supports the teeth. Covered 1 time per quadrant per 24 months.

Partial Pulpotomy for Apexogenesis - Covered on permanent teeth only.

Pin Retention

Prefabricated or Stainless Steel Crown. Covered 1 time per 60 months for *covered persons* through the age of 14.

Therapeutic Drug Injection

Endodontic Services

Endodontic Therapy on Permanent Teeth

- Root Canal Therapy
- Root Canal Retreatment

Other Endodontic Treatments.

- Apexification
- Apicoectomy
- Root amputation
- Hemisection

Periodontal Services

- **Full Mouth Debridement.** This is a non-surgical periodontal service to treat diseases of the gums (gingival) and bone that supports the teeth. Covered 1 time per lifetime.

Complex Surgical Periodontal Care. These services are surgical treatment for diseases of the gums (gingival) and bone that supports the teeth. Only one of the below services is covered per single tooth or multiple teeth in the same quadrant per 36 months. Covered for permanent teeth only.

- Gingivectomy/gingivoplasty
- Gingival flap
- Apically positioned flap
- Osseous surgery
- Bone replacement graft
  the following complex surgical periodontal care services are not subject to the benefit frequency stated above:
- Pedicle soft tissue graft
- Free soft tissue graft
- Subepithelial connective tissue graft
- Soft tissue allograft

Crown Lengthening

Oral Surgery Services

Basic Extractions

- Removal of coronal remnants (retained pieces of the crown portion of the tooth) on primary teeth
- Extraction of erupted tooth or exposed root

Complex Surgical Extractions. Surgical removal of 3rd molars is covered only when symptoms of oral pathology exist.

- Surgical removal of erupted tooth
- Surgical removal of impacted tooth
- Surgical removal of residual tooth roots

Other Complex Surgical Procedures

- Alveoloplasty
- Removal of exostosis-per site

Other Oral Surgery Procedures

- Incision and drainage of abscess (intraoral soft tissue)
- Collect – apply autologous product - Covered 1 time per 36 months.
- Excision of pericoronal gingiva
- Tooth reimplantation – accidentally evulsed or displaced tooth
- Suture of recent small wounds up to 5 cm

Post Surgical Services

- Treatment of complications, unusual circumstances

Intravenous Conscious Sedation, IV Sedation and General Anesthesia. Covered when given with a complex surgical service. The service must be given in a *dentist's* office by the *dentist* or an employee of the *dentist* that is certified in their profession to give anesthesia services.

Major Restorative Services

Gold foil restorations. Covered at the same frequency as an amalgam filling. Gold foil restorations will be paid up to the same *maximum allowed amount* for an amalgam filling. You're responsible to pay for any amount over the *maximum allowed amount*, plus any applicable *deductible* and *coinsurance*.

Inlays. Covered at the same frequency as an amalgam filling. Inlays will be paid up to the same *maximum allowed amount* for an amalgam filling. You're responsible to pay for any amount over the *maximum allowed amount*, plus any applicable *deductible* and *coinsurance*.

Onlays and/or Permanent Crowns. Covered 1 time per 60 months. Only covered on a permanent tooth. To be covered, the tooth must have extensive loss of natural structure due to decay or fracture so that another restoration (such as a filling or inlay) cannot be used to restore the tooth. We will pay up to the *maximum allowed amount* for a porcelain to noble metal crown. If you choose to have another type of crown, you're responsible to pay for the difference plus any applicable *deductible* and *coinsurance*.

Recement an Inlay, Onlay or Crown.

Inlay, Onlay or Crown Repair. Covered 1 time per 36 months. The narrative from your treating *dentist* must support the procedure.

Restorative Cast Post and Core Build-Up. Includes 1 post per tooth and 1 pin per surface. Covered 1 time per 60 months if needed to retain an indirectly fabricated restoration (such as a crown) due to extensive loss of tooth structure due to decay or fracture.

Prefabricated Post and Core (in addition to crown). Covered 1 time per tooth per 60 months.

Occlusal Guards. Covered 1 time per 12 months for *covered persons* age 13 through 18.

Prosthodontic Services

Tissue Conditioning

Reline and Rebase. Covered 1 time per 36 months as long as the appliance (denture, partial or bridge) is the permanent appliance. Covered once 6 months has passed from the initial placement of the appliance.

Repairs and Replacement of Broken Clasp(s)

Replacement of Broken Artificial Teeth. Covered as long as the appliance (denture, partial or bridge) is the permanent appliance. Covered once 6 months has passed from the initial placement of the appliance and the narrative from the treating *dentist* supports the service.

Denture Adjustments

Partial and Bridge Adjustments

Dentures and Partial (removable prosthodontic services. Covered 1 time per 60 months for the replacement of extracted permanent teeth. If you have an existing denture or partial, a replacement is only covered if at least 60 months has passed and it cannot be repaired or adjusted.

Bridges (fixed prosthodontic services. Covered 1 time per 60 months for the replacement of extracted permanent teeth. If you have an existing bridge, a replacement is only covered if at least 60 months has passed and it cannot be repaired or adjusted. In order for the bridge to be covered:

- A natural healthy and sound tooth is present to service as the anterior and posterior retainer.
- There are no other missing teeth in the same arch that have been replaced with a removable partial denture.
- And none of the individual units (teeth) of the bridge has had a crown or cast restoration covered under this *plan* in the last 60 months.

The *plan* will cover the least costly, commonly performed course of treatment. If there are multiple missing teeth, the *plan* may cover a partial denture instead of the bridge. If you still choose to get the bridge, you will be responsible to pay the difference in cost, plus any applicable *deductible* and *coinsurance*.

Recementation of Bridge (fixed prosthetic).

Single Tooth Implant Body, Abutment and Crown - Covered 1 time per 60 months. Coverage includes only the single surgical placement of the implant body, implant abutment and implant/abutment supported crown. Some adjunctive implant services may not be covered. It's recommended that you get a *pretreatment estimate*, so you fully understand the treatment and cost before having implant services done.

Orthodontic Care

Orthodontic care is the prevention and correction of malocclusion of teeth and associated dental and facial disharmonies. Talk to your orthodontist about getting a *pretreatment estimate* for your orthodontic treatment plan, so you have an idea upfront what the treatment and costs will be. You or your orthodontist should send it to us so we can help you understand how much is covered by your benefits.

Dentally Necessary Orthodontic Care
This *plan* will only cover orthodontic care that is dentally necessary – at least one of these criteria must be present:

- Spacing between adjacent teeth that interferes with your biting function
- Overbite that causes the lower front (anterior) teeth to impinge on the roof of your mouth when you bite
- The position of your jaw or teeth impairs your ability to bite or chew
- n an objective, professional orthodontic severity index, your condition scores consistent with needing orthodontic care

What Orthodontic Care Includes.
Orthodontic care may include the following types of treatment:

- Pre-Orthodontic Treatment Exams. Periodic visits with your *dentist* to establish when orthodontic treatment should begin.
- Periodic Orthodontic Treatment Visits
- Limited Treatment. A treatment usually given for minor tooth movement and is not a full treatment case.
- Interceptive Treatment (also known as phase I treatment). This is a limited treatment that is used to prevent or lessen the need for more involved treatment in the future.
- Comprehensive or Complete Treatment. A full kind of treatment that includes all radiographs, diagnostic casts and models, orthodontic appliances and office visits.
- Removable Appliance Therapy. Treatment that uses an appliance that is removable and not cemented or bonded to the teeth.
- Fixed Appliance Therapy. Treatment that uses an appliance that is cemented or bonded to the teeth.
- Complex Surgical Procedures. Surgical procedures given for orthodontic reasons, such as exposing impacted or unerupted teeth, or repositioning of the teeth.

How We Pay for Orthodontic Care
Because orthodontic treatment usually occurs over a long period of time, payments are made over the course of your treatment. In order for us to continue to pay for your orthodontic care, you must have continuous coverage under this policy.

The first payment for orthodontic care is made when treatment begins. Treatment begins when the appliances are installed. Your orthodontist should submit the necessary forms telling us when your appliance is installed. Payments are then made at six month intervals until the treatment is finished or coverage under this policy ends.

If your orthodontic treatment is already in progress (the appliance has been installed) when you begin coverage under this policy, the orthodontic treatment benefit under this coverage will be on a pro-rated basis. We will only cover the portion of orthodontic treatment that you are given while covered under this policy. We will not pay for any portion of your treatment that was given before your *effective date* under this policy.

What Orthodontic Care Does NOT Include. The following is not covered as part of your orthodontic treatment:

- Monthly treatment visits that are billed separately — these costs should already be included in the cost of treatment.
- Repair or replacement of lost, broken, or stolen appliances.
- Orthodontic retention or retainers that are billed separately — these costs should already be included in the cost of treatment.
- Retreatment and services given due to a relapse.
- Inpatient or outpatient hospital expenses, unless covered by the medical benefits of this [policy].
- Any provisional splinting, temporary procedures or interim stabilization of the teeth.

Adult Dental

We cover the following dental care services for members over age 18 when they are performed by a licensed *dentist*, and when necessary and customary as determined by the standards of generally accepted dental practice. If there is more than one professionally acceptable treatment for your dental condition, we will cover the least expensive.

Diagnostic and Preventive Services

Oral Evaluations - Any type of evaluation (checkup or exam) is covered 2 times per calendar year.

Radiographs (X-rays)

- **Bitewings** - Covered at 1 series of bitewings per 24 months.
- **Full Mouth (Complete Series) or Panoramic** - Covered 1 time per 60 months.
- **Periapical(s)** - 4 single x-rays are covered per 12 months.
- **Occlusal** - Covered at 2 series per 24 months.

Dental Cleaning (**Prophylaxis)** - Prophylaxis is a procedure to remove plaque, tartar (calculus), and stain from teeth. Any combination of this procedure and Periodontal Maintenance (See Periodontal Services) are covered 2 times per calendar year.

Basic Restorative Services

Emergency Treatment - Emergency (palliative) treatment for the temporary relief of pain or infection.

Amalgam (silver) Restorations - Treatment to restore decayed or fractured permanent or primary teeth.

Composite (white) Resin Restorations

- Anterior (front) Teeth - Treatment to restore decayed or fractured permanent or primary anterior (front) teeth.
- Posterior (back) Teeth - Treatment to restore decayed or fractured permanent or primary posterior (back) teeth.

  Benefits will be limited to the same surfaces and allowances for amalgam (silver filling). The patient must pay the difference in cost between the *maximum allowed amount* for the *covered service* and the optional treatment, plus any *deductible* and/or *coinsurance* that applies.

LIMITATION: Coverage for amalgam or composite restorations will be limited to 1 service per tooth surface per 24 months.

Basic Extractions

- Removal of coronal remnants (retained pieces of the crown portion of the tooth) on primary teeth
- Extraction of erupted tooth or exposed root

Brush Biopsy - Covered 1 time per 36 months, per *covered person* age 20 to 39. Covered 1 time per 12 months per *covered person* age 40 and above.

Endodontic Services

Endodontic Therapy on Primary Teeth

- **Pulpal Therapy**
- **Therapeutic Pulpotomy**

Endodontic Therapy on Permanent Teeth

- **Root Canal Therapy**
- **Root Canal Retreatment**

LIMITATION: All of the above procedures are covered 1 time per tooth per lifetime.

Periodontal Services

Periodontal Maintenance - A procedure that includes removal of bacteria from the gum pocket areas, scaling and polishing of the teeth, periodontal evaluation and gum pocket measurements for patients who have completed previous surgical or nonsurgical periodontal treatment.

LIMITATION: Any combination of this procedure and dental cleanings (see Diagnostic and Preventive section) is covered 2 times per calendar year.

Basic Non-Surgical Periodontal Care - Treatment of diseases of the gingival (gums) and bone supporting the teeth.

- Periodontal scaling & root planing - Covered 1 time per 36 months if the tooth has a pocket depth of 4 millimeters or greater.
- Full mouth debridement - Covered 1 time per lifetime.

Complex Surgical Periodontal Care - Surgical treatment of diseases of the gingival (gums) and bone supporting the teeth. The following services are considered complex surgical periodontal services under this *policy*.

- Gingivectomy/gingivoplasty;
- Gingival flap;
- Apically positioned flap;
- Osseous surgery;
- Bone replacement graft;
- Pedicle soft tissue graft;
- Free soft tissue graft;
- Subepithelial connective tissue graft;
- Soft tissue allograft;
- Combined connective tissue and double pedicle graft;
- Distal/proximal wedge - Covered on natural teeth only

LIMITATION: Only 1 complex surgical periodontal service is covered per 36 months per single tooth or multiple teeth in the same quadrant and only if the pocket depth of the tooth is 5 millimeters or greater.

Oral Surgery Services

Complex Surgical Extractions

- Surgical removal of erupted tooth
- Surgical removal of impacted tooth
- Surgical removal of residual tooth roots

LIMITATION: Surgical removal of 3rd molars is only covered if the removal is associated with symptoms or oral pathology.

Other Complex Surgical Procedures

- Alveoloplasty
- Vestibuloplasty
- Removal of exostosis-per site
- Surgical reduction of osseous tuberosity

LIMITATION: The Other Complex Surgical Procedures are covered only when required to prepare for dentures and is a benefit covered once in a 60 months.

Surgical Reduction of Fibrous Tuberosity - Covered 1 time per 6 months.

Adjunctive General Services

- Intravenous Conscious Sedation, IV Sedation and General Anesthesia - Covered when performed in conjunction with complex surgical services.

Major Restorative Services

Gold foil restorations - Receive an amalgam (silver filling) benefit equal to the same number of surfaces and allowances.

LIMITATION: The patient must pay the difference in cost between the *maximum allowed amount* for the *covered services* and optional treatment, plus any *deductible* and/or *coinsurance* that applies. Covered 1 time per 24 months.

Inlays - Benefit will equal an amalgam (silver) restoration for the same number of surfaces.

LIMITATION: If an inlay is performed to restore a posterior (back) tooth with a metal, porcelain, or any composite (white) based resin material, the patient must pay the difference in cost between the *maximum allowed amount* for the *covered service* and optional treatment, plus any *deductible* and/or *coinsurance* that applies.

Onlays and/or Permanent Crowns - Covered 1 time per 7 years if the tooth has extensive loss of natural tooth structure due to decay or tooth fracture such that a restoration cannot be used to restore the tooth.

LIMITATION**:** Porcelain/ceramic substrate onlays/crowns – Benefits will be limited to the *maximum allowed amount* for a porcelain to noble metal crown. The patient must pay the difference in cost between the *maximum allowed amount* for the *covered service* and optional treatment, plus any applicable *deductible* and/or *coinsurance*.

Implant Crowns - See Prosthodontic Services.

Recement Inlay, Onlay and Crowns - Covered 6 months after initial placement.

Crown Repair - Covered 1 time per 12 months per tooth when the submitted narrative from the treating *dentist* supports the procedure.

Restorative cast post and core build-up, including 1 post per tooth and 1 pin per surface - Covered 1 time per 7 years when necessary to retain an indirectly fabricated restoration due to extensive loss of actual tooth structure due to caries or fracture.

Prosthodontic Services

Tissue Conditioning - Covered 1 time per 24 months.

Reline and Rebase - Covered 1 time per 24 months:

- When the prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance; and
- Only after 6 months following initial placement of the prosthetic appliance (denture, partial or bridge).

Repairs, Replacement of Broken Artificial Teeth, Replacement of Broken Clasp(s) - Covered 1 time per 6 months:

- When the prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance;
- Only after 6 months following initial placement of the prosthetic appliance (denture, partial or bridge); and
- When the submitted narrative from the treating *dentist* supports the procedure.

Denture Adjustments - Covered 2 times per 12 months:

- When the denture is the permanent prosthetic appliance; and
- Only after 6 months following initial placement of the denture.

Partial and Bridge Adjustments - Covered 2 times per 24 months:

- When the partial or bridge is the permanent prosthetic appliance; and
- Only after 6 months following initial placement of the partial or bridge.

Removable Prosthodontic Services (Dentures and Partials) - Covered 1 time per 7 years:

- For the replacement of extracted (removed) permanent teeth;
- If 7 years have elapsed since the last covered removable prosthetic appliance (denture or partial) and the existing denture or partial cannot be repaired or adjusted.

Fixed Prosthodontic Services (Bridge) - Covered 1 time per 7 years:

- For the replacement of extracted (removed) permanent teeth;
- If no more than 3 teeth are missing in the same arch;
- A natural, healthy, sound tooth is present to serve as the anterior and posterior retainer;
- No other missing teeth in the same arch that have not been replaced with a removable partial denture;
- If none of the individual units of the bridge has been covered previously as a crown or cast restoration in the last 7 years;
- If 7 years have elapsed since the last covered removable prosthetic appliance (bridge) and the existing bridge cannot be repaired or adjusted.

LIMITATION: If there are multiple missing teeth, a removable partial denture may be the benefit since it would be the least costly, commonly performed course of treatment. The optional benefit is subject to all *contract* limitations on the *covered service*.

Recement Fixed Prosthetic - Covered 1 time per 12 months.

Single Tooth Implant Body, Abutment and Crown - Covered 1 time per 7 years for *covered persons* age 16 and over. Coverage includes only the single surgical placement of the implant body, implant abutment and implant/abutment supported crown.

LIMITATION: Some adjunctive implant services may not be covered. It is recommended that a *pretreatment estimate* be requested to estimate the amount of payment prior to beginning treatment.

EXCLUSIONS

Coverage is NOT provided for:

- For any condition, disease, defect, ailment or injury arising out of and in the course of employment if benefits are available under the Workers' Compensation Act or any similar law. This exclusion applies if a *covered person* receives the benefits in whole or in part. This exclusion also applies whether or not the *covered person* claims the benefits or compensation. It also applies whether or not the *covered person* recovers from any third party.
- *Dental services* or health care services not specifically covered under the *plan* (including any hospital charges, prescription drug charges and *dental services* or supplies that are medical in nature).
- New, experimental or investigational dental techniques or services may be denied until there is, to our satisfaction, an established scientific basis for recommendation.
- *Dental services* completed prior to the date the *covered person* became eligible for coverage.
- Services of anesthesiologists.
- Anesthesia Services, except when given with covered complex surgical services and given by a *dentist* or by an employee of the *dentist* when the service is performed in his or her office who is certified in their profession to provide anesthesia services.
- Analgesia, analgesia agents, anxiolysis nitrous oxide, medicines, or drugs for non-surgical or surgical dental care.
- Intravenous conscious sedation, IV sedation and general anesthesia when given separate from a covered complex surgical procedure.
- *Dental services* performed other than by a licensed *dentist*, licensed physician, his or her employees.
- *Dental services*, appliances or restorations that are necessary to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
- Services or supplies that have the primary purpose of improving the appearance of your teeth. This includes but is not limited to tooth whitening agents or tooth bonding and veneer covering of the teeth.
- Case presentations.
- Incomplete, interim or temporary services, including but not limited to fixed prosthetic appliances (dentures, partials or bridges).
- Enamel microabrasion and odontoplasty.
- Retreatment or additional treatment necessary to correct or relieve the results of treatment previously benefited under the *policy*.
- Bacteriologic tests.
- Cytology sample collection.
- Separate services billed when they are an inherent component of another *covered service*.
- Services for the replacement of an existing partial denture with a bridge.
- Additional, elective or enhanced prosthodontic procedures including but not limited to, connector bar(s), stress breakers and precision attachments.
- Provisional splinting, temporary procedures or interim stabilization.
- Services or supplies that are medical in nature, including dental oral surgery services performed in a hospital.

- Pulp vitality tests.
- Adjunctive diagnostic tests.
- Incomplete root canals.
- Cone beam images.
- Anatomical crown exposure.
- Temporary anchorage devices.
- Sinus augmentation.
- Amalgam or composite restorations, inlays, onlays and/or crowns placed for preventive or cosmetic purposes.
- Temporomandibular Joint Disorder (TMJ) except as covered under your medical coverage.
- Oral hygiene instructions.
- Repair or replacement of lost/broken appliances are not a covered benefit.
- Removal of pulpal debridement, pulp cap, post, pin(s), resorbable or non-resorbable filling material(s) and the procedures used to prepare and place material(s) in the canals (root).
- Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.
- The controlled release of therapeutic agents or biologic modifiers used to aid in soft tissue and osseous tissue regeneration.
- Any material grafted onto bone or soft tissue, including procedures necessary for guided tissue regeneration.
- Initial installation of an implant(s), full or partial dentures or fixed bridgework to replace a tooth (teeth) which was extracted prior to becoming a *covered person* under this *policy*. EXCEPTION: This exclusion will not apply for any person who has been continuously covered for more than 24 months.
- For *covered persons* age 19 and older, corrections of congenital conditions during the first 24 months of continuous coverage under this *policy*.
- Dental implant maintenance or repair to an implant or implant abutment.
- [Orthodontic services for *covered persons* age 19 and older.]

GENERAL PROVISIONS

IMPORTANT INFORMATION REGARDING YOUR INSURANCE

In the event you need to contact someone about this insurance for any reasons please contact your agent. If no agent was involved in the sale of this insurance or if you have any additional questions you may you may contact Anthem at the following address and telephone number: [PO Box 9385, Minneapolis, MN 55440-9305 and (800) 234-9009.]

Form or content of certificate

No agent or employee of the *plan* is authorized to change the form or content of this *certificate*. Such changes can be made only through an endorsement authorized and signed by an officer of the *plan*.

Relationship of parties (*plan* - *participating dentists*)

The relationship between the *plan* and *participating dentists* is an independent contractor relationship. *Participating dentists* are not agents or employees of the *plan*, nor is the *plan*, or any employee of the *plan*, an employee or agent of *participating dentists*.

The *plan* shall not be responsible for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by a *covered person* while receiving care from any *participating dentist* or in any *participating dentist's* facilities.

Your *participating dentist's* agreement for providing *covered services* may include financial incentives or risk sharing relationships related to provision of services or referrals to other *providers,* including *participating dentists* and *non-participating dentists*. If you have questions regarding such incentives or risk sharing relationships, please contact your *provider* or the *plan*.

Not liable for provider acts or omissions

The *plan* is not responsible for the actual care you receive from any person. This *certificate* does not give anyone any claim, right, or cause of action against the *plan* based on what a *provider* of dental care, services or supplies, does or does not do.

Identification card

Your *identification card* identifies the dental program in which you are enrolled. When you receive care from a *participating* or *non-participating dentist*, you must show your *identification card*. Possession of an *identification card* confers no right to services or other benefits under this *certificate*. To be entitled to such services or benefits you must be a *covered person* on whose behalf all applicable *premiums* under this *certificate* have been paid. If you receive services or other benefits to which you are not then entitled under the provisions of this *certificate* you will be responsible for the actual cost of such services or benefits.

Circumstances beyond the control of the plan

In the event of circumstances not within the control of the *plan*, including but not limited to, a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil insurrection, labor disputes not within the control of the *plan*, disability of a significant part of a *participating dentist's* personnel or similar causes, or the rendering of dental care services provided under this *certificate* is delayed or rendered impractical, the *plan* shall make a good-faith effort to arrange for an alternative method of providing coverage. In such event, the *plan* and *participating dentists* shall render dental care services provided under this *certificate* insofar as practical, and according to their best judgment; but the *plan* and

participating dentists shall incur no liability or obligation for delay, or failure to provide or arrange for services if such failure or delay is caused by such an event.

Employer premiums

Your employer is responsible for paying a monthly *premium* by the first day of the month for which coverage is purchased. We will allow employers a 31 day grace period to pay monthly *premiums*, except for the first month's *premium*. During this grace period, coverage will continue unless we receive a written notice of termination from your employer. We will notify your employer at least 15 days prior to terminating the *group contract* for non-payment of a monthly *premium*. Anthem is not responsible for costs you incur during any period (other than the grace period discussed above) when your employer fails to pay full *premiums*.

[Extension of benefits

If this dental *certificate* terminates, benefits will be continued for a period of 60 days for the following:

1. The installation of new appliances and modifications to appliances for which a master impression was made prior to the benefit termination date.
2. An installation of a crown, bridge, or cast restoration for which the tooth was prepared prior to the benefit termination date.
3. Root canal therapy, for which the pulp chamber was opened prior to the benefit termination date.
4. Orthodontic treatment which began prior to the benefit termination date.]

Coordination of Benefits

Special coordination of benefits (COB) rules apply when you or members of your family have additional dental care coverage through other group dental plans, including:

- group insurance plans, including other Anthem plans;
- labor management trustee plans, union welfare plans, employer welfare plans, employer organization plans, or employee benefit organization plans; and
- coverage under any tax-supported or government program to the extent permitted by law.

All benefits provided under this agreement are subject to this provision. However, benefits will not be increased by this COB provision. This provision applies if the total payment under this agreement absent this provision and under any other contract is greater than the value of *covered services*.

Primary coverage and secondary coverage. When a member is also enrolled in another group dental plan, one coverage will pay benefits first (be primary) and the other will pay second (be secondary). The primary coverage will pay benefits first. The decision of which coverage will be primary or secondary is made using benefit determination rules.

When we provide secondary coverage, we first calculate the amount that would have been payable had we been primary. Then we coordinate benefits so that the combination of the primary plan's payment and our payment does not exceed the amount we would have paid had it been primary.

Definition of "Other Contract". Other contract means any arrangement providing dental care benefits or services through:

- group or blanket insurance coverage;
- group Anthem, health maintenance organization, and other prepayment coverage;
- coverage under labor management trusteed plans, union welfare plans, employer organization plans, or employee benefit organization plans; and
- coverage under any tax supported or government program to the extent permitted by law.

If there is more than one other contract, this provision will apply separately to each. If another contract

has a coordination of benefits provision that applies to only part of its services, the terms of this paragraph will be applied separately to that part and to any other part.

Anthem will not determine the existence of any other contract, or the amount of benefits payable under any other contract except this agreement. The payment of benefits under this agreement shall be affected by the benefits payable under other contracts only when Anthem is given information about other contracts.

If the rules of this agreement and the other contract both provide that this agreement is primary, then this agreement is primary. When Anthem determines that this agreement is secondary under the rules described below, benefits will be coordinated so that our payment plus the other contract's payment will not exceed Anthem *maximum allowed amount* for *covered services*.

Order of Benefit Determination Rules

1. Pediatric Dental Coordination of Benefits (COB). If pediatric dental *essential health benefits* are included as part of the medical plan, the medical plan will be the primary coverage and any standalone dental plan will be secondary.
2. If you have two dental plans, the plan which includes pediatric dental *essential health benefits* will be the primary coverage.
3. If neither of the above applies, the Order of Benefit Determination Rules below will determine the coordination of benefits.
4. If you are covered under one plan as a primary insured and another plan as a *dependent*, the plan under which you are the primary insured will be the primary coverage.
5. As required by law, if you or a *dependent* also has coverage under Medicare, this plan will always be primary.
6. For children who are covered under both parents' contracts, the following will apply:
    a. The contract of the parent whose birthday occurs earlier in the calendar year will be primary.
    b. When parents are separated or divorced, the following special rules will apply:
        i. If the parent with custody has not remarried, that parent's contract will be primary.
        ii. If the parent with custody has remarried, that parent's contract will be primary and the stepparent's contract will be secondary. The benefits of the contract of the parent without custody will be determined last.
        iii. The rules listed above may be changed by a court decree:
            - A court decree that orders one of the parents to be responsible for health care expenses will cause that parent's contract to be primary, but only if the entity providing the benefits in this case is notified of the court decree before applying benefits.
            - If the court decree does not state that one of the parents is responsible for health care expenses and both parents have joint custody, the contract of the parent whose birthday occurs earlier in the calendar year will be primary.

7. If the other contract includes the gender rule, then that rule will be used instead of the rules listed above. The gender rule states that the father's contract will be primary for the children.
8. If there are situations not covered above, then the contract that has been in effect the longest period of time (without interruption) will be primary. There is an exception to this rule. The contract that covers a working employee (or his *dependent*) will be primary. The contract of a laid-off employee, a retired employee, or a person on continuation of coverage options under federal or state law will be secondary.
9. If another contract has different rules from those listed above other than the gender rule, that contract will be primary.

If payments should have been made under this agreement under the rules of this provision, but they have been made under any other contract, Anthem may pay an entity (*provider*, other carrier, etc.) that has paid any amounts it determines will meet the intent of this provision. These amounts shall be deemed to be

benefits paid under this agreement. Upon this payment, Anthem will no longer be liable under this agreement.

Relationship of parties (*group-covered person-plan*)

Neither the *group* nor any *covered person* is the agent or representative of the *plan*.

The *group* is fiduciary agent of the *covered person*. The *plan's* notice to the *group* will constitute effective notice to the *covered person*. It is the *group's* duty to notify the *plan* of eligibility data in a timely manner. The *plan* is not responsible for payment of *covered services* of *covered persons* if the *group* fails to provide the *plan* with timely notification of *covered person* enrollments or terminations.

Conformity with law

Any provision of this *certificate* which is in conflict with the laws of the state in which the *group dental contract* is issued, or with federal law, is hereby automatically amended to conform with the minimum requirements of such laws.

Modifications

This *certificate* allows the *group* to make the *plan* coverage available to eligible *covered persons*. However, this *certificate* shall be subject to amendment, modification, and termination in accordance with any of its provisions, the *group dental contract*, or by mutual agreement between the *plan* and the *group* without the permission or involvement of any *covered person*. Changes will not be effective until 30 days after we provide written notice to the *group* about the change. By accepting the *plan* benefits, all *covered persons* who are legally capable of entering into a contract, and the legal representatives of all *covered persons* that are incapable of entering into a contract, agree to all terms, conditions, and provisions in this *certificate*.

Changes to your premium
In the event your *premium* is increased, we will notify you at least 60 days before the change takes effect.

Physical examination and autopsy

We shall have the right to: (1) examine any *covered person* for whom a claim is made when and as often as may be reasonably required during the pendency of a claim; and (2) perform an autopsy on any *covered person* where it is not otherwise prohibited by law.

Time for suits

You may not take legal action against us to receive benefits:

- Earlier than 60 days after we receive the claim; or
- Later than two years after the date the claim is required to be furnished to us or the date of service.

You must exhaust the *plan's* Grievance and Appeal Procedures before filing a lawsuit or other legal action of any kind against us.

Punitive damages

In the event that you or your representative sue us or any of our directors, officers or employees acting in his or her capacity as a director, officer or employee for a determination of what coverage, if any, exists under this *certificate*, your damages will be limited to the amount of your claim for benefits.

The damages may not exceed the amount of any claim not properly paid as of the date the lawsuit is filed. This *certificate* does not provide coverage for punitive damages, or damages for emotional distress or mental anguish. However, this provision is not intended, and will not be construed, to affect in any manner, any recovery by you or your representative of any non contractual damages to which you or your representative may otherwise be entitled.

CLAIM AND APPEAL PROCEDURES

All claims should be submitted within 12 months of the date of service. However, your claim will not be invalidated or reduced if you can prove that you could not reasonably give notice within that time period and that you did give notice as soon as it was reasonably possible to do so. An initial benefit determination on your claim will be made within 30 days after receipt of your claim. You will receive written notification of this benefit determination. The 30-day period may be extended for an additional 15 days if the claim determination is delayed for reasons beyond our control. In that case, we will notify you prior to the expiration of the initial 30-day period of the circumstances requiring an extension and the date by which we expect to render a decision. If the extension is necessary to obtain additional information from you, the notice will describe the specific information we need, and you will have 45 days from the receipt of the notice to provide the information. Without complete information, your claim will be denied.

Appeals
In the event that we deny a claim in whole or in part, you have a right to a full and fair review. Your request to review a claim must be in writing and submitted within 180 days from the claim denial. We will make a benefit determination within 60 days following receipt of your *appeal*.

Your *appeal* must include your name, your identification number, *group* number, claim number, and *dentist's* name as shown on the Explanation of Benefits. Send your *appeal* to:

[Anthem Blue Cross and Blue Shield
Attention: Appeals Unit
PO Box 1122
Minneapolis, MN 55440-1122]

You may submit written comments, documents, or other information in support of your *appeal*. You will also be provided, upon request and free of charge, reasonable access to and copies of all relevant records used in making the decision. The review will take into account all information regarding the denied or reduced claim (whether or not presented or available at the initial determination) and the initial determination will not be given any weight.

The review will be conducted by someone different from the original decision-makers and without deference to any prior decision. Because all benefit determinations are based on a preset schedule of *dental services* eligible under your *plan*, claims are not reviewed to determine dental necessity or appropriateness. In all cases where professional judgment is required to determine if a procedure is covered under your *plan's* Summary of Benefits, we will consult with a dental professional who has appropriate training and experience. In such a case, this professional will not be the same individual whose advice was obtained in connection with the initial adverse benefit determination (nor a subordinate of any such individual). In addition, we will identify any dental professional whose advice was obtained on our behalf, without regard to whether the advice was relied upon in making the benefit determination. If, after review, we continue to deny the claim, you will be notified in writing.

Authorized representative
You may authorize another person to represent you and with whom you want us to communicate regarding specific claims or an *appeal*. However, no authorization is required for your treating *dentist* to make a claim or *appeal* on your behalf. The authorization form must be in writing, signed by you, and include all the information required in our Authorized Representative form. This form is available at our web site or by calling member service [at (877) 604-2156]. You can revoke the authorized representative at any time, and you can authorize only one person as your representative at a time.

GET HELP IN YOUR LANGUAGE

Curious to know what all this says? We would be too. Here's the English version:
You have the right to get this information and help in your language for free. Call the member services number on your *ID card* for help. **(TTY/TDD: 711)**

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the member service telephone number on the back of your *ID card*.

Spanish
Tiene el derecho de obtener esta información y ayuda en su idioma en forma gratuita. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación para obtener ayuda**. (TTY/TDD: 711)**

Arabic
يحق لك الحصول على هذه المعلومات والمساعدة بلغتك مجانًا. اتصل برقم خدمات الأعضاء الموجود على بطاقة التعريف الخاصة بك للمساعدة.
(TTY/TDD:711)

Chinese
您有權使用您的語言免費獲得該資訊和協助。請撥打您的 ID 卡上的成員服務號碼尋求協助。**(TTY/TDD: 711)**

Dinka
Yin nɔŋ yic ba ye lëk në yök ku bë yi kuɔny në thöŋ yin jäm ke cin wëu töu kë piiny. Cɔl rän töŋ dë kɔc kë luɔi në nämba dën tɔ̈ në I.D kat du yic. **(TTY/TDD: 711)**

French
Vous avez le droit d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour cela, veuillez appeler le numéro des Services destinés aux membres qui figure sur votre carte d'identification. **(TTY/TDD: 711)**

German
Sie haben das Recht, diese Informationen und Unterstützung kostenlos in Ihrer Sprache zu erhalten. Rufen Sie die auf Ihrer ID-Karte angegebene Servicenummer für Mitglieder an, um Hilfe anzufordern. **(TTY/TDD: 711)**

Japanese
この情報と支援を希望する言語で無料で受けることができます。支援を受けるには、IDカードに記載されているメンバーサービス番号に電話してください。**(TTY/TDD: 711)**

Khmer
អ្នកមានសិទ្ធិក្នុងការទទួលព័ត៌មាននេះ និងទទួលជំនួយជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។
សូមហៅទូរស័ព្ទទៅលេខសេវាសមាជិកដែលមានលើប័ណ្ណ ID របស់អ្នកដើម្បីទទួលជំនួយ។
(TTY/TDD: 711)

Korean
귀하에게는 무료로 이 정보를 얻고 귀하의 언어로 도움을 받을 권리가 있습니다. 도움을 얻으려면 귀하의 ID 카드에 있는 회원 서비스 번호로 전화하십시오. **(TTY/TDD: 711)**

Oromo
Odeeffanoo kana fi gargaarsa afaan keetiin kaffaltii malee argachuuf mirga qabda. Gargaarsa argachuuf lakkoofsa bilbilaa tajaajila miseensaa (member services) waraqaa enyummaa kee irratti argamu irratti bilbili. **(TTY/TDD: 711)**

Polish
Masz prawo do bezpłatnego otrzymania niniejszych informacji oraz uzyskania pomocy w swoim języku. W tym celu skontaktuj się z Działem Obsługi Klienta pod numerem telefonu podanym na karcie identyfikacyjnej. **(TTY/TDD: 711)**

Russian
Вы имеете право получить данную информацию и помощь на вашем языке бесплатно. Для получения помощи звоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. **(TTY/TDD: 711)**

Tagalog
May karapatan kayong makuha ang impormasyon at tulong na ito sa ginagamit ninyong wika nang walang bayad. Tumawag sa numero ng member services na nasa inyong *ID card* para sa tulong. **(TTY/TDD: 711)**

Thai
ท่านมีสิทธิขอรับบริการสอบถามข้อมูลและความช่วยเหลือในภาษาของท่านฟรี
โทรไปที่หมายเลขฝ่ายบริการสมาชิกบนบัตรประจำตัวของท่านเพื่อขอความช่วยเหลือ **(TTY/TDD: 711)**

Vietnamese
Quý vị có quyền nhận miễn phí thông tin này và sự trợ giúp bằng ngôn ngữ của quý vị. Hãy gọi cho số Dịch Vụ Thành Viên trên thẻ ID của quý vị để được giúp đỡ. **(TTY/TDD: 711)**

It's important we treat you fairly
That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services?
Call the member services number on your *ID card* for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, PO Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.